General

Guideline Title

Management of vaginal discharge in non-genitourinary medicine settings.

Bibliographic Source(s)

Faculty of Sexual and Reproductive Healthcare (FSRH), British Association for Sexual Health and HIV (BASHH). Management of vaginal discharge in non-genitourinary medicine settings. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2012 Feb. 28 p. [97 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Royal College of Obstetricians & Gynaecologists, British Association for Sexual Health and HIV. The management of women of reproductive age attending non-genitourinary medicine settings complaining of vaginal discharge. J Fam Plann Reprod Health Care 2006 Jan;32(1):33-42; quiz 42. [42 references]

Recommendations

Major Recommendations

The recommendation grades (A to C, Good Practice Point) are defined at the end of the "Major Recommendations" field.

What Are the Commonest Causes of Altered Vaginal Discharge in Women of Reproductive Age?

Health professionals should be aware that the most common causes of altered vaginal discharge are physiological, bacterial vaginosis (BV) and candida, but sexually transmitted infections (STIs) and non-infective causes must be considered. (Good Practice Point)

Refer to Table 1 in the original guideline document for additional information.

Management of Women Presenting with Vaginal Discharge

Examination, Point-of-Care Investigations and STI Testing

A detailed history, including sexual history, is essential to identify the necessary investigations and treatment options. (Good Practice Point)

Women experiencing vaginal discharge who are at low risk of STI can be treated by syndromic or empirical management (see Figure 1 In the original guideline document). (Grade C)

All women with persistent vaginal discharge should be examined to exclude serious pathology. (Good Practice Point)

Laboratory Investigations

Women assessed as being at risk of STI, or who request testing, should be offered appropriate tests for chlamydia, gonorrhoea, syphilis and human immunodeficiency virus (HIV). (Good Practice Point)

A high vaginal swab (HVS) is of limited diagnostic value in the management of vaginal discharge except in cases of inconclusive assessment, recurrent symptoms, treatment failure, or in pregnancy, postpartum, post-abortion or post-instrumentation. (Good Practice Point)

Which Treatments Are Appropriate for Women Complaining of Vaginal Discharge?

Treatment of Non-sexually Transmitted Infections

Bacterial Vaginosis

Metronidazole and clindamycin administered either orally or vaginally are effective in the treatment of BV. (Grade A)

In the management of BV, testing and treatment of male sexual partners is not indicated but testing and treatment of female sexual partners can be considered. (Grade C)

Vulvovaginal Candidiasis (VVC)

Vaginal and oral azole antifungals are equally effective in the treatment of VVC. (Grade A)

Women with vulval symptoms of VVC may use topical antifungals (in addition to oral or vaginal treatment) until symptoms resolve. (Good Practice Point)

There is no need for routine screening or treatment of sexual partners in the management of candidiasis. (Grade C)

Treatment of Sexually Transmitted Infections

Trichomonas Vaginalis (TV)

Oral nitroimidazole drugs (e.g., metronidazole) are effective in treating trichomoniasis. (Grade A)

Current sexual partners of women diagnosed with TV should be offered a full sexual health screen and should be treated for TV irrespective of the results of their tests. (Grade B)

Management of Vaginal Discharge in Special Circumstances

Vaginal Discharge in Pregnancy

Bacterial Vaginosis

Women with BV who are pregnant or breastfeeding may use metronidazole 400 mg twice daily for 5–7 days or intravaginal therapies. A 2 g stat dose of metronidazole is not recommended in pregnancy or breastfeeding women. (Grade C)

Vulvovaginal Candidiasis

Women with VVC in pregnancy should avoid oral antifungals. (Grade C)

Women with VVC in pregnancy can be treated with topical imidazoles. Single-dose treatment is less effective than longer regimens of up to 7 days. (Grade A)

Vaginal Discharge in Women with Human Immunodeficiency Virus (HIV)

Trichomonas Vaginalis

For HIV-positive women with TV, longer treatment regimens with oral metronidazole may be more effective than a single dose. (Grade B)

Recurrent Vaginal Discharge

Recurrent BV

For women with recurrent BV, suppressive treatment with metronidazole vaginal gel may be considered. Evidence to support other regimens is limited. (Grade A)

Women using acidifying gels for recurrent BV can be advised to use them alternate evenings for 1 month or longer if required. (Good Practice Point)

Recurrent VVC

For women with recurrent VVC, an induction and maintenance regimen may be used for 6 months. (Grade B)

Recurrent TV

Recurrent TV is usually due to re-infection, but consideration should be given to the possibility of drug resistance. (Grade C)

Contraception and Vaginal Discharge

Is the Efficacy of Contraception Affected by Vaginal Discharge Treatments?

Additional contraceptive precautions are not required when using antibiotics that do not induce liver enzymes. (Grade D)

Women and male partners should be advised that latex contraceptives may be damaged by some vaginal/vulval antifungal treatments. (Grade C)

Does Contraception Affect Vaginal Discharge?

Women using combined hormonal contraception (CHC) who experience recurrent VVC may wish to consider switching to an alternative method of contraception. (Grade C)

Women with a copper-bearing intrauterine device (Cu-IUD) who experience recurrent BV may wish to consider switching to an alternative method of contraception. (Grade C)

Personal Hygiene and Vaginal Discharge

Women experiencing vaginal discharge can be advised to avoid douching and local irritants as part of general management. (Grade C)

Definitions:

Grading of Recommendations

A: Evidence based on randomised controlled trials (RCTs)

B: Evidence based on other robust experimental or observational studies

C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point: Where no evidence exists but where best practice is based on the clinical experience of the expert group

Clinical Algorithm(s)

A clinical algorithm for the management of vaginal discharge in non-genitourinary medicine settings is provided in the original guideline document.

Scope

Disease/Condition(s)

- Vaginal discharge
- Bacterial vaginosis
- Vulvovaginal candidiasis
- Sexually transmitted infections caused by *Trichomonas vaginalis* (TV, trichomoniasis)

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Infectious Diseases

Internal Medicine

Obstetrics and Gynecology

Intended Users

Advanced Practice Nurses

Nurses

Patients

Physician Assistants

Physicians

Guideline Objective(s)

To provide information for health professionals working in non-genitourinary medicine (GUM) settings on management of vaginal discharge in women of reproductive age

Target Population

Women of reproductive age with vaginal discharge, including pregnant and breastfeeding women and women with human immunodeficiency virus (HIV) infection, and their sexual partners

Note: This document is not intended to provide comprehensive guidance on discharge in pregnancy or after surgical procedures where local protocols or specific guidance may apply. The management of vaginal discharge in children and postmenopausal women is outside the scope of this guidance.

Interventions and Practices Considered

Diagnosis/Evaluation

1. Consideration of infective and other causes for vaginal discharge (e.g. foreign body, cervical ectopy)
2. Clinical and sexual history and assessment of risk factors
3. Assessment of symptoms
4. Use of point-of-care investigations, including physical examination and measurement of vaginal pH
5. Liaison with local laboratory on specimen processing and information provided
6. Lab investigations including endocervical or high vaginal swabs, microscopy, gram stain, culture, nucleic acid amplification tests

7. Offering appropriate tests for chlamydia, gonorrhoea, syphilis and human immunodeficiency virus (HIV)

Treatment/Management

1. Oral or vaginal metronidazole or clindamycin for bacterial vaginosis (BV)
2. Testing and treatment of the male sexual partner(s) for candidiasis or BV (considered but not recommended)
3. Testing and treatment of female sexual partners for BV
4. Oral, vaginal, or vulval antifungals (azoles) for vulvovaginal candidiasis (VVC)
5. Oral nitroimidazole drugs (e.g., metronidazole for) trichomoniasis vaginalis
6. Full sexual health screen and treatment of male sexual partners for trichomoniasis vaginalis
7. Special considerations for women during pregnancy, for HIV-infected women, and for recurrent infection
8. Advising women that latex contraceptives may be damaged by some vaginal/vulval antifungal treatments
9. Advising women using combined hormonal contraception who experience recurrent VVC that they may wish to consider switching to an alternative method of contraception
10. Advising women with a copper-bearing intrauterine device who experience recurrent BV that they may wish to consider switching to an alternative method of contraception
11. Advising women experiencing vaginal discharge to avoid douching and local irritants as part of general management

Note: Routine screening for *Trichomonas vaginalis* in pregnancy was considered but not recommended.

Major Outcomes Considered

Sensitivity, specificity, and utility of diagnostic tests
Initial cure rates
Relapse rates

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Evidence was identified using a systematic literature review and electronic searches were performed for: MEDLINE (CD Ovid version) (1996–2012); EMBASE (1996–2012); PubMed (1996–2012); The Cochrane Library (to 2012) and the US National Guideline Clearinghouse. The searches were performed using relevant medical subject headings (MeSH), terms and text words. The Cochrane Library was searched for relevant systematic reviews, meta-analyses and controlled trials relevant to vaginal discharge. Previously existing guidelines from the Faculty of Sexual and Reproductive Healthcare (FSRH) (formerly the Faculty of Family Planning and Reproductive Health Care), the Royal College of Obstetricians and Gynaecologists (RCOG), the World Health Organization (WHO) and the British Association for Sexual Health and HIV (BASHH), and reference lists of identified publications, are also searched.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Not Given)

Rating Scheme for the Strength of the Evidence

Not stated

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

All papers are graded according to the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. Recommendations are graded using a scheme similar to that adopted by the Royal College of Obstetricians and Gynaecologists (RCOG) and other guideline development organisations. The clinical recommendations within this guidance are based on evidence whenever possible. Summary evidence tables are available on request from the Clinical Effectiveness Unit (CEU). The methods used in the development of this guidance have been accredited by National Health Service (NHS) Evidence.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

A multidisciplinary group (MDG) is appointed by invitation to the main stakeholders. The Clinical Effectiveness Unit (CEU) and MDG revise the key questions, and a systematic literature review, critical appraisal, and development of evidence tables is performed by the CEU researcher.

Draft one of the guidance document is written by the CEU. The MDG holds a one-day meeting to peer review the document and provide written feedback. Draft two of the guidance document is prepared by the MDG, the Faculty of Sexual and Reproductive Healthcare (FSRH) Clinical Effectiveness Committee (CEC) and two independent peer reviewers.

Draft three of the guideline is prepared, based on written feedback, and the MDG is asked to review the guidance and recommendations using a formal consensus process, after which draft four is prepared. This draft document is published on the Faculty Web site for 1 month for public consultation. Stakeholders are informed of this consensus process. All feedback comments are reviewed by the CEU, MDG, and FSRH CEC. The final draft is prepared, and the CEU's response to consultation comments is posted on the FSRH Web site.

The final guidance document is published by the FSRH. Print copies are mailed to FSRH members and a Portable Document Format (PDF) version of the guidance is available on the FSRH Web site. Post-publication feedback is reviewed by the CEC and the web version is amended as and when necessary.

Rating Scheme for the Strength of the Recommendations

Grading of Recommendations

A: Evidence based on randomised controlled trials (RCTs)

B: Evidence based on other robust experimental or observational studies

C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities

Good Practice Point: Where no evidence exists but where best practice is based on the clinical experience of the expert group

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Draft three of the guideline is prepared, based on written feedback, and the MDG is asked to review the guidance and recommendations using a formal consensus process, after which draft four is prepared. This draft document is published on the Faculty Web site for 1 month for public consultation. Stakeholders are informed of this consensus process. All feedback comments are reviewed by the CEU, MDG, and FSRH CEC. The final draft is prepared, and the CEU's response to consultation comments is posted on the FSRH Web site.

The British Association for Sexual Health and HIV public patient involvement group reviewed the guideline.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of women of reproductive age with vaginal discharge attending non-genitourinary medicine (GMU) settings

Potential Harms

- Preparations containing econazole, miconazole, isoconazole, fenticonazole or clotrimazole may damage latex contraceptives. Clindamycin cream may also weaken condoms.
- Side effects of oral metronidazole include metallic taste and gastrointestinal symptoms.
- Oral clindamycin is associated with pseudomembranous colitis.

Contraindications

Contraindications

- Alcohol should be avoided for the duration of treatment with nitroimidazole drugs (e.g., metronidazole and tinidazole) and for 48 hours afterwards because of the possibility of a disulfiram-like (Antabuse® effect) reaction.
- Women with vulvovaginal candidiasis (VVC) in pregnancy should avoid oral antifungals.

Qualifying Statements

Qualifying Statements

Recommendations are based on available evidence and consensus opinion of experts. They should be used to guide clinical practice but they are not intended to serve alone as a standard of medical care or to replace clinical judgment in the management of individual cases.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Clinical Algorithm

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Faculty of Sexual and Reproductive Healthcare (FSRH), British Association for Sexual Health and HIV (BASHH). Management of vaginal discharge in non-genitourinary medicine settings. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2012 Feb. 28 p. [97 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2006 Jan (revised 2012 Feb)

Guideline Developer(s)

British Association for Sexual Health and HIV - Medical Specialty Society

Faculty of Sexual and Reproductive Healthcare - Professional Association

Source(s) of Funding

Faculty of Sexual and Reproductive Healthcare

Guideline Committee

Clinical Effectiveness Unit

Composition of Group That Authored the Guideline

Guideline Development Group: Dr Louise Melvin (Director, Clinical Effectiveness Unit); Ms Julie Craik (Researcher, Clinical Effectiveness Unit); Dr Michael Abbott (FSRH Clinical Effectiveness Committee representative, Consultant Genitourinary Medicine Physician, Southport and Formby DGH, Southport); Professor John E Coia (Consultant Clinical Microbiologist, Department of Clinical Microbiology, Glasgow Royal Infirmary, Glasgow); Dr Amanda Davies (Subspecialty Trainee in Sexual & Reproductive Health, Aneurin Bevan Health Board, Wales); Dr Jane Dickson (FSRH Clinical Standards Committee representative, Community Specialist in Contraception and Sexual Health, Woolwich, London); Dr Fiona Fargie (Sexual Health & HIV Consultant, Sandyford, Glasgow); Mrs Lorraine Forster (FSRH Meetings Committee representative, Head of Nursing, Sandyford, Glasgow); Mrs Lynn Hearton (FSRH Clinical Effectiveness Committee representative, Helpline & Information Services Manager, Family Planning Association, London); Professor Cathy Ison (Director of the Sexually Transmitted Bacteria Reference Laboratory, Health Protection Agency, Microbiology Services, London); Dr Carmel Kelly (Lead Nurse Sexual Health, Downe Hospital, Downpatrick); Dr Neil Lazaro (BASHH representative, Associate Specialist Genitourinary Medicine, HIV, Royal Preston Hospital, Fulwood, Preston); Dr Rona MacDonald (Specialist Trainee in Genitourinary Medicine, Sandyford, Glasgow); Dr David J White (BASHH representative, Consultant in Sexual Health and HIV Medicine, Heartlands Hospital, Birmingham); Dr Janet Wilson (BASHH representative, Consultant in Genitourinary Medicine, Leeds General Infirmary, Leeds)

Administrative support to the CEU team was provided by Ms Janice Paterson.

Financial Disclosures/Conflicts of Interest

No significant interests were declared.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Royal College of Obstetricians & Gynaecologists, British Association for Sexual Health and HIV. The management of women of reproductive age attending non-genitourinary medicine settings complaining of vaginal discharge. J Fam Plann Reprod Health Care 2006 Jan;32(1):33-42; quiz 42. [42 references]

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the Faculty of Sexual and Reproductive Healthcare Web site

.

Print copies: Available from the Faculty of Sexual and Reproductive Healthcare Web site, 27 Sussex Place, Regent's Park, London NW1 4RG

Availability of Companion Documents

Discussion points and questions for the management of vaginal discharge in non-genitourinary medicine setting developed by the Faculty of Sexual and Reproductive Healthcare Meetings Committee are available in the original guideline document .

In addition, auditable outcomes are provided in the original guideline document .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on May 15, 2006. The information was verified by the guideline developer on May 19, 2006. This NGC summary was updated by ECRI Institute on May 9, 2012.

Copyright Statement

Disclaimer

NGC Disclaimer